COVID-19: Community Midwives, Public Health, and Emergency Preparedness

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- This webinar is being recorded and will be available in a few days
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Executive Director
Over 20 years of grantmaking to advance midwifery in North America
Grant-making organization 501 (c )(3) non-profit

Grants made to:

- MANA Statistics Project, Division of Research of the Midwives Alliance of North America
- Allied midwifery organizations
- Community-based organizations
- See what FAM funds formidwifery.org/projects-funded

FAM’s Mission:
Improve maternal and child health by funding projects that advance midwifery as the gold standard for North American maternity care through
- research,
- public education,
- advocacy,
- and health equity initiatives.
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Published March 23, 2020

During a pandemic, out-of-hospital birth is essential to minimizing transmission, maintaining health, and efficiently utilizing medical resources. Midwives who specialize in out-of-hospital birth should be involved in emergency planning for maternity care during a pandemic. [read more]
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Formidwifery.org

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Shifting Perspectives:
The Community Midwife in Our New Public Health Reality

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Adjunct Faculty, Bastyr University, Kenmore WA
Volunteer, Public Health/Medical Reserve Corps, King County, WA
Co-founder Disaster Preparedness & Response Caucus, ACNM
Objectives

1. Describe how Contingency and Crisis Standards of Care for Public Health Emergencies relate to community-based midwives and settings.

2. Briefly discuss the literature on disaster bioethics and healthcare practitioner moral distress and resilience.

3. Consider ethical challenges and values alignment when incorporating a public health perspective to midwifery practice during an epidemic or pandemic.
Before

- Community Based Midwifery Practice
- Public Health Practice

Image from PixelSquid
Now (or coming soon to your neighborhood...)

- Sweeping new powers, both medically and legally using Utilitarian ethics
- Recommendations are made with imperfect evidence, medical model approach, & little or no understanding of CB midwifery

Public Health Practice

Community Based Midwifery Practice

- Decreased Autonomy
- New uncertain ideas about Beneficence & Non-maleficence
- Other ways of thinking about Justice (fairness)
Crisis Standards of Care

The first decade of the 21st century in the U.S. saw 9/11 & anthrax, Hurricane Katrina, and H1N1. These stressors exposed how ill-prepared our nation was to handle mass casualty events. In 2009, the IOM (Institute of Medicine) convened a workshop to discuss healthcare in the contexts of terrorism, disasters, and pandemics.

A systems framework approach called “Crisis Standards of Care” was developed from the concept of “altered standards of care,” long used by disaster responders and the military.

How Are Crisis Standards of Care Different?

Focus of Normal Care

Individual patient

Focus of Crisis Care

Community

Gostin et al., 2020; IOM/NAP 2010; Leider et al, 2011
There are no bright lines between the cells in this table. The situation can change daily or hourly – it’s always fluid and unpredictable and sometimes unclear in real time.

<table>
<thead>
<tr>
<th>Incident demand/resource imbalance increases</th>
<th>Risk of morbidity/mortality to patient increases &amp; loss of autonomy, support, privacy</th>
<th>Recovery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conventional</td>
<td>Contingency</td>
<td>Crisis</td>
</tr>
<tr>
<td>Space</td>
<td>Patient care areas re-purposed (PACU, monitored units for ICU-level care)</td>
<td>Facility damaged/unsafe or non-patient care areas (classrooms, etc.) used for patient care</td>
</tr>
<tr>
<td>Staff</td>
<td>Staff extension (brief deferrals of non-emergent service, supervision of broader group of patients, change in responsibilities, documentation, etc.)</td>
<td>Trained staff unavailable or unable to adequately care for volume of patients even with extension techniques</td>
</tr>
<tr>
<td>Supplies</td>
<td>Conservation, adaptation, and substitution of supplies with occasional re-use of select supplies</td>
<td>Critical supplies lacking, possible re-allocation of life-sustaining resources</td>
</tr>
<tr>
<td>Standard of care</td>
<td>Functionally equivalent care</td>
<td>Crisis standards of carea</td>
</tr>
<tr>
<td>Normal operating conditions</td>
<td>Indicator: potential for crisis standardsb</td>
<td>Trigger: crisis standards of carec</td>
</tr>
</tbody>
</table>

Epic times, practice is desperate, uncharted waters, doing more with less, everyone sacrifices
Federal and state governments use the Crisis Standards of Care (CSC) concept as a macro system-wide approach, but I believe that the continuum of conventional, contingency, and crisis standards can apply to the meso- (county) and micro- (individual practice) levels also.

Hick et al., 2020; IOM/NAP 2012, p.132
Shifting towards CSC always requires grappling with clinical issues that are also moral/ethical issues which affect midwives deeply on both professional and personal levels. For example, with Covid-19:

- Reducing the number of in-person clinic visits; telehealth
- Wearing medical PPE
- Accepting late transfers of panicked pregnant people fleeing the hospitals
- Number of support people during labor
- Questioning water birth
- Removing newly born babies from new parents
- Struggling to figure out who to prioritize, and when and how? Family or clients?
- A million more...

The midwife has to wrestle with all this in a context of information overload, deficiencies, and contradictions.

Furthermore, the licensed/certified midwife must balance their “provider roles as an agent of the state, public health department, professional certification body, & individual clients”.

Gebbie et al., 2009, p.113; Holt, 2008, p. 183
“Moral distress” is a concept that first emerged in the nursing literature in the 1980s (Jameton, 1984).

“Crisis standards of care” do not mean a lowered standard of care. The legal and ethical standard is still to do what a ‘prudent’ midwife with similar training and experience would do under similar circumstances. “No emergency changes the basic standards of practice, code of ethics, competence, or values of the professional” (Gebbie et al., 2009, p. 111-2; Schultz & Annas, 2012). However...

Practitioners are often hindered during public health crises in following their professional ethics and inner moral values – the clinical situations are increasingly out of our control. Each course of action seems to pose a dilemma regarding the right decision to make, the right thing to do. No matter what we recommend or decide, outcomes are uncertain and a moral residue remains (Gustavsson et al., 2020; O'Mathuna, 2016; Thomas & McCullough, 2015).

Moral fraying or distress occurs when the situation is extreme, or when challenges keep piling on. You feel frustrated, powerless, angry, remorseful, regretful, and like we are letting our clients, ourselves, and our profession down (Gustavsson, 2020; Thomas & McC, 2015).

The erosion of personal and professional moral integrity can leave us feeling confused, adrift, and existentially threatened (Gustavsson et al, 2020; Thomas & McCullough, 2015). Or we cope by putting our heads in the sand and denying the shifting realities around us.
Mitigating Moral Distress

- **Thinking and talking it through** with others is one of the best coping strategies
  - **Take a ‘Non-Ideal Approach’**: “There can be no absolute, predetermined answers to the many specific questions that arise in any emergency event.” **Acknowledge** with your clients that decisions must be made with incomplete information and evidence, but do not forget what we DO know about health, safety, parenthood, and empowerment – this stuff *still matters*. You CAN maintain your values – find them in the decisions you make.
  - **Share** ideas, resources, and emotional journeys with other midwives in your area – and give each other permission to take your emotional temperature and talk to you if they sense secondary traumatic distress, or questionable client care due to compassion fatigue, disconnection, or magical thinking.
  - **Seek** out information to inform your thinking and critical analyses. Study and seek rationalizations for the CDC and public health department’s recommendations, and the new clinical guidelines that say different things.
  - **Solidarity**: Find out what the people you normally interface with in the hospital (physicians, nurses, etc.) and EMS system are thinking about – what is important to them and who might be affected by protocols you are developing for your practice. We are all stakeholders with unique positions in this new world we are navigating, and being humble in our own understandings and taking into account the needs of everyone can be beneficial.
  - **Connect** with your local and national midwifery associations (like attending this webinar) to expose yourself to how other midwives are dealing with Covid-19 where they live, taking note of clever ideas and “lessons learned”. Take on a **leadership** role, and encourage others to do so, so we don’t lose control of midwifery.
  - **Self-care**, of course
  - **Plan** for debriefing, feeling pride in professionalism (adapting & providing essential care in extreme conditions), long-term support, and preparing together for the next emergency when this current crisis is behind us.

Gebbie et al., 2009; Gustavsson et al., 2020, O’Mathuna, 2016
We’re all alone in this together!

Prevention-Mitigation

Preparedness

Recovery

Response

Image from City of Avondale, AZ
References

Conflict of Interest Disclosure Statement

No Conflicts of Interest
Punctuated Equilibrium

Rethinking Prenatal Care and Regional Collaboration

Autumn Vergo NHCM, CPM
“...Gould posits, most species have originated during punctuated geologic moments, and persisted through the periods of stasis that followed. Just as, more than a century ago, quantum theory proved that in physics, things sometimes moved forward in spurts, Gould intuited that this was also true for aspects of evolutionary biology.” —The Atlantic
Cheshire Medical Center DHH: Clinic (Ambulatory) Initial Response Goals

To maintain high standards of quality care.

To protect staff and patients by reducing in-person contact.

To grow and evolve by adopting new practices which further our mission even beyond the pandemic response.
Immediate Actions

- Postponement of elective surgery and procedures
- Schedule Sorting:
  - Urgent/Critical
  - Routine
  - Prenatal Care
- Implementation of telehealth, including telephone office visits, telehealth with video, and group activities (Centering Pregnancy, Childbirth Education)

DHH: https://med.dartmouth-hitchcock.org/connected-care.html
Redesigning Prenatal Care

- Hospital L&D Closures
- Patient Satisfaction
- Centering Model Success
- Remote Clinics
- Decline in CBE Enrollment
- Inconvenient Hours
- Clinical Practice Guidance
Published Prenatal Care Guidance: Ob NEST

• Study protocol published in 2015, single center RCT results 12/2019 in AJOG.

• Test arm
  • Pregnant women, aged 18–36 years
  • 8 onsite appointments with an obstetric provider
  • 6 virtual visits consisting of phone or online communication with RN
  • Home monitoring with fetal Doppler and BP cuff
  • Access to an online community of pregnant women.

• Outcomes: no perceived difference in quality of care. Both control and test arms adhered to ACOG standards to PNC. Ob outcomes similar.
Published Prenatal Care Guidance: WHO

- High quality, comprehensive clinical practice guideline for prenatal care.
- Assessed methodological rigor and transparency of development via AGREE II instrument.
- Updated visit frequency, more aligned with ACOG/ common practice in USA.
- This provided the visit structure, overlaid with our typical labs and education.

### Box 5: Comparing ANC schedules

<table>
<thead>
<tr>
<th>WHO FANC model</th>
<th>2016 WHO ANC model</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>First trimester</strong></td>
<td></td>
</tr>
<tr>
<td>Visit 1: 8-12 weeks</td>
<td>Contact 1: up to 12 weeks</td>
</tr>
<tr>
<td><strong>Second trimester</strong></td>
<td></td>
</tr>
<tr>
<td>Visit 2: 24-26 weeks</td>
<td>Contact 2: 20 weeks</td>
</tr>
<tr>
<td></td>
<td>Contact 3: 26 weeks</td>
</tr>
<tr>
<td><strong>Third trimester</strong></td>
<td></td>
</tr>
<tr>
<td>Visit 3: 32 weeks</td>
<td>Contact 4: 30 weeks</td>
</tr>
<tr>
<td></td>
<td>Contact 5: 34 weeks</td>
</tr>
<tr>
<td>Visit 4: 36-38 weeks</td>
<td>Contact 6: 36 weeks</td>
</tr>
<tr>
<td></td>
<td>Contact 7: 38 weeks</td>
</tr>
<tr>
<td></td>
<td>Contact 8: 40 weeks</td>
</tr>
</tbody>
</table>

Return for delivery at 41 weeks if not given birth.
Cheshire Medical Center DHH WHO CarePath

- Intake < 12 Weeks: TELEPHONE/TELEHEALTH Visit with Prenatal Care Coordinator. Intake surveys, genetic counseling referral, early GDM screen, PN labs, obtain BP cuff & scale, order dating ultrasound.

- 10-12 Weeks: IN PERSON Visit with Provider. H&P, BP cuff calibration/teaching, draw labs, paperwork for genetic screening, immunizations, FHT or bedside ultrasound, serum screen only or NIPT part 1, order morphology ultrasound.

- 14-16 Weeks: LAB VISIT ONLY (if necessary for serum screen part 2, MSAFP, or quad) PHONE CALL to review results and check in.

- 20 Weeks: IN PERSON Morphology Ultrasound, PHONE CALL to review results and start Plan of Supportive Care, lab visit for integrated screening part 2, QUAD, MSAFP if NIPT.


- 26-28 Weeks: IN PERSON Visit with Provider. GTT same-day, T&S and RhoGam if indicated, repeat syphilis and HIV if indicated, sign tubal consent, sign VBAC consent, TDaP.

- 28 Weeks: TELEPHONE/TELEHEALTH Visit with Prenatal Care Coordinator, Preterm labor precautions, Breastfeeding education.

- 30-32 Weeks: IN PERSON Visit with Provider. Review birth plan, fundal height, schedule PRCS if indicated.

- 34 Weeks: PHONE VISIT with Provider. Postpartum planning, Breastfeeding and infant care education, Plan of Supportive Care, Review PTL precautions and kick counts.

- 36 Weeks: IN PERSON Visit with Provider. GBS, Fundal height, repeat HIV/GCCT for high risk, labor precautions.


- 40 Weeks: IN PERSON Visit with Provider. Schedule IOL or postdates testing.
Cheshire Medical Center DHH: Regional Response Goals

To maintain high standards of quality care.

To coordinate information sharing and strategies for cohorting patients, providers, and staff across our region’s three community hospitals and one freestanding birth center.

To grow and evolve by adopting new practices *which further our mission even beyond the pandemic response.*
Regional Practice Landscape
Regional Strategic Planning

• Freestanding Birth Center: Cohorting well patients, information-sharing, policy alignment (visitors), status of staffing and PPE. Daily check-in.

• Community Hospitals: Cohorting well patients, “disaster” privileges for providers, nursing resources, PPE resources, downtime charting, diversion planning, information sharing, census and transfer information.

• Agreement in concept: We will maintain awareness of each others’ status. We will help each other out, and we clarified how to communicate a status change or ask for help.
The Daily/Weekly Checklist

- Patient Census
- Staff and Provider Status
- Any changes to:
  - Screening policy
  - Visitor policy
- Any Clinical Guidance Changes (Information Sharing)
- Review Transfers (Between Practices)
- Review Transfers (From Away)
References


COVID-19
Washington State Midwifery Mobilization

Emily Jones, MS in Midwifery candidate, Bastyr University

Jen Segadelli, JD, MSM, CPM Co-President, Midwives’ Association of Washington State

Jodilyn Owen, LM-CPM Clinical Director, Rainier Valley Midwives on behalf of Tara Lawal, MS, RN Executive Director, Rainier Valley Midwives
**WA State Midwifery COVID-19 Response Coalition**

- Tiered System of Perinatal Care
- Alternate Care Facility designations
- Supply acquisition
- Midwifery Collective
- Birth bundle packages
Tiered System of Perinatal Care

TIER 1: COVID-Designated Hospital Childbirth Units

TIER 2: COVID-Free Hospital Childbirth Units

TIER 3: COVID-Free Freestanding Birth Centers (FSBCs)

TIER 4: COVID-Free Field Site

Alternate Care Facilities
Alternate Care Facility

Often used to alleviate pressure on overwhelmed hospital systems in the event of a surge in clients or as a result of incapacitated medical infrastructure. Selected based on convenience, scalability, and location, ACFs can expand the scope of existing medical facilities as necessary to respond to the crisis/event at hand.
Supply acquisition for community midwives

3 Health Care Coalition (HCC) leads in WA State

- Ongoing weekly supply request submissions
- 6 volunteers in this committee taskforce, each representing 2-3 counties

Requested supplies

- PPE: non-sterile gloves, sterile gloves, procedure masks, face shields, gowns, shoe covers
- Routine medical supplies
A Midwifery Collective: Model and Considerations

- Structure
- Liability Insurance
- PP&Ps
- Practice Guidelines
- Contractual commitment
- Orientation & training
  - Review of emergency skills
  - Expectations, auditing, feedback, discipline
- Reimbursement
Healing our communities, one family at a time

Build your Birth Bundle
www.myrvcc.org

Midwifery Led

Social Health Services

Physician Collaboration

Lactation Support

Birth Doula
Scaling up the Birth Bundle: [H2H]

- Activates bundle model of doula-midwifery collaboration
- At-home a/m of labor until 6cm
- Remove postpartum doula
- Add in 2 mental health visits
  - Anxiety/depression
  - Domestic violence
  - Child Abuse
- Ante/Intra/Post partum home kits
  - Minimize equipment in-and-out of homes
  - Increases agency and education
Máiri Breen Rothman, CNM, DrMid
Director, M.A.M.A.S., Inc.
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What is Amy’s Place?
Why we need this model
Design
Staffing
Medical support
Transfers
What If’s
Why we need this model

- Used in most other countries with better outcomes than ours, before COVID19
- Keeps healthy low-risk birthing people and babies separate from hospitals
- Increases capacity of midwives to attend more people
- Keeps hospital rooms free for sick people and birthing people with risk factors or complications
- Similar to navy ships taking non-COVID patients
Why we are minimizing direct contact

Dr. Robert Signer and graphic designer Gary Warshaw
Institute for Health Metrics & Eval (UW)

https://covid19.healthdata.org/?fbclid=IwAR1mwKplJqMY9Dch-9mBXcnLz1GVGbkmK9DqeCmoNjrjBRjeauUrAS7mc8

- Enough beds
- not enough ICU beds
- Long arc until August
WHO/ICM Recommendations

ICM statement on Midwives and Disaster Preparedness:

- Women and marginalized groups are particularly ill prepared for survival and recovery from a disaster.
- Preparation is difficult due to unexpectedness and unpredictability.
- Saving lives/preventing and reducing suffering is an enormous task, which requires preparation and competence.
- Responses to disaster often start at community level, and it is only after the initial emergency phase that emergency agencies step up.
- Midwives are part of the health workforce, often work closest to the affected community, so their preparedness and response are vital.
- Midwives often not included in emergency preparedness/response planning despite WHO lists maternal, newborn health essential to mass casualty management.
- Midwives must be supported to take-up their role in disaster preparedness and rapid response.
ICM recognizes

- the importance of disaster/emergency preparedness
- vulnerable position of women, marginalized groups and children
- importance strategies that incorporate equity and social justice
- midwives are essential for the provision of birthing person & newborn health services in a situation of disaster/emergency.

Midwives are in a unique position to support breastfeeding and safe infant feeding during times of natural disaster or emergency.

Midwives should be deployed, as part of a team, during a disaster.
ICM encourages organizations to

- In the short term, assist in efforts to mobilize the necessary resources for midwifery care in disaster/emergency situations
- Work with existing capacities, skills, resources, and organizational structures
- Partner with independent, objective media, local and national branches of government, international agencies, and non-governmental organizations.
- Care for midwives and others who provide direct services.
- Encourage midwives to continue to provide ongoing care and support to birthing and lactating people
THE WAY IT WORKS--DESIGN

- Entrance—shelters
- Screening
- Admission Lounge
  - Showers/changing rooms/robes/storage bins
  - Precip room
- Midwifery Unit
  - 6 self-contained pods of 4 rooms each
  - 24 rooms (one midwife team room for every 3 birth rooms)
- Birthing Dyad Transport Unit
  - Appropriately equipped
  - Appropriately staffed
Staffing

- Midwives
- Birth Assistants
- Doulas
- Transport Unit Staff
- Admissions staff
- Administrative staff
- Janitorial staff
How it works

- Pre-admission communication
- Screening—healthy people, uncomplicated pregnancy
- Admission/Sanitizing procedure
- Precip room
- Midwifery unit
- Birthing Dyad Transport Unit
- Discharge—5 things + NB exam + instructions
- Postpartum
  - f/u w/original provider
  - MUST have plan for immediate PP follow-up
COVID 19 Postpartum Planning

Postpartum and Pediatric Visits

- 1 day, 3 day PP visits
- 2 day pediatric visit
- Midwife may need extra visit, depending on peds
COVID 19 Clinical Practice Guidelines

INTRAPARTUM CARE

- Admission
- Labor management
  - Intermittent auscultation
  - Labor support
- Midwives/BAs/Doulas
- Emergency service
  - 24hr ready transport
  - Qualified transport staff

Pre-Admission Screening
- Separate area, no staff crossover
- OB and Covid 19 screening
- ACOG Algorithm
- Referral plans for sick women
- Admission lounge
- Precip area
ACOG COVID-19 protocols

Outpatient Assessment and Management for Pregnant Women With Suspected or Confirmed Novel Coronavirus (COVID-19)

Unlike influenza and other respiratory illnesses, based on a limited number of confirmed COVID-19 cases, pregnant women do not appear to be at increased risk for severe disease. However, given the lack of data and experience with other coronaviruses such as SARS-CoV and MERS-CoV, diligence in evaluating and treating pregnant women is warranted.

This algorithm is designed to aid practitioners in promptly evaluating and treating pregnant persons with known exposure and/or those with symptoms consistent with COVID-19 (persons under investigation [PUI]). If influenza viruses are still circulating, influenza may be a cause of respiratory symptoms and practitioners are encouraged to use the ACOG/SMFM influenza algorithm to assess need for influenza treatment or prophylaxis.

Please be advised that COVID-19 is a rapidly evolving situation and this guidance may become out-of-date as new information on COVID-19 in pregnant women becomes available from the Centers for Disease Control and Prevention (CDC). https://www.cdc.gov/mmwr/ndr/ndr6905.htm

**Assess Patient’s Symptoms**
- Symptoms typically include fever >38°C (100.4°F) or one or more of the following:
  - Cough
  - Difficulty breathing or shortness of breath
  - Gastrointestinal symptoms

**Conduct Illness Severity Assessment**
- Does she have difficulty breathing or shortness of breath?
- Does she have difficulty completing a sentence without pausing for air or needing to stop to catch her breath frequently when walking across the room?
- Does patient cough more than 1 teaspoon of blood?
- Does she have new pain or pressure in the chest other than pain with coughing?
- Is she unable to keep fluids down?
- Does she show signs of dehydration such as dizziness when standing?
- Is she less responsive than normal or does she become confused when talking to her?

**Elevated Risk**
- Recommended she immediately seek care in an emergency department or equivalent unit that treats pregnant women. When possible, send patient to a setting where she can be isolated.
- Notifying the facility that you are relaying a PUI is recommended to minimize the chance of spreading infection to other patients and healthcare workers at the facility
- Adhere to local infection control practices including personal protective equipment

**Moderate Risk**
- See patient as soon as possible in an ambulatory setting with resources to determine severity of illness.
- When possible, send patient to a setting where she can be isolated.
- Clinical assessment for respiratory compromise includes physical examination and tests such as pulse oximetry, chest X-ray, or ABG as clinically indicated.
- Pregnant women with abdominal edema should not be excluded from chest CT if clinically recommended.

**Low Risk**
- Refer patient for symptomatic care at home including hydration and rest.
- Monitor for development of any symptoms above and re-start algorithm if new symptoms present.
- Routine obstetric precautions

Abbreviations: ABG, arterial blood gases; CDC, Centers for Disease Control and Prevention; HIV, human immunodeficiency virus.

Healthcare providers should immediately notify their local/state health department in the event of a PUI for COVID-19 and should contact and consult with their local/state health department for recommendations on testing PUIs for COVID-19.
WHAT IF

- Someone needs an emergency c-section?
- A person comes in too late to go through admission process?
- A staff person gets sick?
- A patient gets sick?
- A newborn gets sick?
- A person develops pregnancy complications?
- A person doesn’t arrive in a car?
Hurdles to jump

- One all-encompassing bill or governor’s executive order:
  - Permissions/Regulations/licensing
  - Funding
    - Design
    - Construction
    - Supplies/equipment
    - Staffing
  - Liability
  - Insurance coverage
- Relationships—WAH and other hospitals and agencies
SOME THINGS DON’T HAVE TO CHANGE

THINGS THAT WE CAN CONTINUE DOING:

- Our respect for the birthing person at the center of care
- Preserving whatever we can of their birth plans
- Finding ways to create community in new paradigms
- Holding the space for physiologic birth and breastfeeding
- Our calm and loving presence and desire to help
- Our patience and fortitude

REMEMBER TO PUT ON YOUR OWN OXYGEN FIRST!
RESOURCES

World Health Organization
https://www.who.int/emergencies/diseases/novel-coronavirus-2019

CDC Info for Health Care Professionals

ACNM Monitoring Coronavirus
https://www.midwife.org/monitoring-covid-19

CDC Environmental Cleaning and Disinfection Regulations
Mairi Breen Rothman, CNM, DM
Director, M.A.M.A.S., Inc.
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Wishing you a sharp mind, strong heart, and steady hands
♥️
Petition to Governor Cooper
requesting an emergency order allowing CPMs to practice during COVID-19 pandemic

Presented by Meredith Bowden, CPM
• Allow Certified Professional Midwives to practice unencumbered for the duration of this current pandemic crisis

• Require NC hospitals and providers to accept transfers in a collegial and professional manner

• Assist CPMs and CNMs working in community settings to obtain PPE, basic life-saving medications and oxygen refills

• Support families hiring CPMs with financial reimbursement

• Upon resolution, create a task force to develop a process to grant licensure and add CPMs to NC emergency preparedness teams
~ Next Steps ~

• Follow-up correspondence that includes:
  Information about other State’s Emergency Orders
  ACOG Committee Opinion 726 and COVID-19 FAQ
  Links to relevant news articles across NC
  Statistics on how many CPMs could step into practice
• Inform supportive Legislators of our efforts
• Expand our DHHS contacts
• Media attention
• Identify the perinatal subcommittee members in charge of disaster preparedness at hospitals
• Encourage/allow our message to be shared from a variety of organizations
PLEASE TYPE YOUR QUESTION
Thank you for joining us!

- **Midwives & the U.S. Census: Making Sure Every Child Counts**
  Thursday, April 23 1:00-2:30 ET

- The webinar recording will be available in the next week at nacpm.org

- Please **complete** the follow-up survey to give us feedback on your experience.

- Support the important work of NACPM by joining today: